SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF WESTCHESTER

----------X

JAMES DAVIS,

Plaintiff,

- against -

EVAN KRAKOVITZ, ARPAN GOEL, ERIC FISHMAN, RICHARD SCHUTZER, SERENA MAK, KONSTANTIN MILLERMAN, FRANTZ TORCHON, EVA RUBIN, MISBAHUDDIN KHAJA, ROBIN GOLDBERG, DEBRA SPICEHANDLER, JONATHAN FINEGOLD, JAMES EHRLICH, MARK PERALTA, KAROLINA WEISS, NANCY CHUNG, MARCIN KARCZ SHIRANDA RHODEN, BRONXVILLE CARDIOLOGY, ASSOCIATES, P.C., DOCTORS UNITED, INC., WESTCHESTER MEDICAL GROUP, P.C. d/b/a WESTMED, LAWRENCE MEDICAL ASSOCIATES, P.C. a/k/a NEW YORK-PRESBYTERIAN MEDICAL GROUP/ WESTCHESTER, COLUMBIA UNIVERSITY MEDICAL CENTER d/b/a COLUMBIA DOCTORS, NEW YORK-PRESBYTERIAN HEALTHCARE SYSTEM, INC., and NEW YORK-PRESBYTERIAN/LAWRENCE HOSPITAL, a/k/a LAWRENCE HOSPITAL CENTER,

Defendants.

----------X

Index No.: 64768/2017

DECISION and ORDER
Defendant Eric Fishman
Mtn. for Summary Judgment

Seq. No. 4

Hubert, JSC

Before the Court is the motion of the Defendant Eric Fishman (the Defendant) seeking an order from the Court pursuant to CPLR § 3212 granting summary judgment against the Plaintiff James Davis and dismissing in its entirety the Plaintiff's action alleging medical malpractice against the Defendant. The Court has reviewed the submissions of the parties, as posted under NYSCEF Index No. 64768/2017, filed in support of and in opposition to the motion of the Defendant. Upon due consideration it is the decision of the Court that the Defendant's motion be granted.

The Plaintiff's Surgery

The Plaintiff's action filed against the Defendant arose from the events that occurred at Lawrence Hospital (the Hospital) on April 28, 2017. The Plaintiff went to the Hospital that day to meet with Dr. Evan Krakovitz (a colo-rectal surgeon), for an elective laparoscopic appendectomy of the appendix after a cystic mass (mucocele) had been discovered at the base thereof in a prior radiological study.

According to Dr. Krakovitz, the Plaintiff was referred to him by either the Plaintiff's primary physician or by a gastroenterologist. In any event Dr. Krakovitz was the Plaintiff's physician and surgeon for the appendectomy. A consent form was filled out and signed by the Plaintiff, and the expected risks, benefits, and complications were discussed with the Plaintiff by Dr. Krakovitz prior to commencement of the surgery (see Operative Report, Exhibit M, at p. 426, and Krakovitz Deposition, p.165-168).

The Defendant, Dr. Fishman was not present at the Hospital when the Plaintiff arrived there and signed the consent form after consultation with Dr. Krakovitz. In fact, the Defendant had no previous contact with the Plaintiff prior to the April 28, 2017 surgery. Indeed, Dr. Fishman was not scheduled to perform surgery on April 28, 2017 with any patient, and was not scheduled to be at the Hospital on that date.

The Defendant was not an employee of the Hospital on the date in question. Pursuant to his deposition, Dr. Fishman was employed by Westmed (Westchester Medical Group) (Fishman Deposition, p. 8). However, on April 28, 2017 Dr. Fishman was registered with the Hospital to be on call and come to the Hospital in the event of an emergency and/or need for his services and consultation. The Defendant, being a board certified vascular surgeon, was thus available in the

event that his skills were needed. His relationship with the Hospital was as an independent physician with privileges allowing, *inter alia*, call response.

According to the Operative Report (Exhibit M, p. 435) the Plaintiff's appendectomy surgery was commenced by Dr. Krakovitz at approximately 4:19 p.m. During the procedure Dr. Krakovitz made use of a "trocar," a surgical instrument used during laparoscopic surgery to penetrate a body cavity and gain intra-abdominal access. However, Dr. Krakovitz was unable to make the trocar gain full entry into the peritoneum membrane which lined the cavity of the abdomen and the abdominal organs therein. Thus Dr. Krakovitz stopped the trocar abdominal surgical approach and performed open access to the abdomen via an incision he made near the umbilicus. The trocar was inserted there and "insufflated" (blew) medication into the area. A camera was placed in the entry port and Dr. Krakovitz was then able to see the trocar entering through the peritoneum and into the abdomen. With the camera, he was able to identify the appendix and the "mass," and removed both through the umbilicus port.

However, immediately after removal of the appendix, Dr. Krakovitz noticed blood in the area of the mesentery (a fold of the peritoneum that attaches the stomach, small intestine and other organs). He made a six to eight inch incision which allowed him better visualization to see the blood. He could not, however, determine from where the blood was originating (Krakovitz Deposition, pp. 169 -183). At this point, Dr. Krakovitz requested the paging of an assistant surgeon to come in and help find out where the bleeding was coming from (Krakovitz Deposition, pp. 183 -184).

While waiting for the appearance of an assistant surgeon, Dr. Krakovitz continued his efforts to locate where the blood was coming from. He pressured the area to stem the bleeding.

The anesthesia doctor was advised that blood would be needed and should be given to the Plaintiff.

Pursuant to Dr. Krakovitz's request for assistance, Dr. Arpan Goel, a general surgeon, was paged to assist Dr. Krakovitz. According to the Operative Report (Exhibit M, p. 435), Dr. Goel arrived at the Operating Room (O.R.) at "1757" hours (5:57 p.m.). Along with Dr. Krakovitz, Dr. Goel helped keep pressure on the area in the Plaintiff's abdomen that was bleeding. The two surgeons also examined the site.

More bruising of the mesentery, and some blood pooling, was observed. It was enough to require new laparotomy pads every five minutes. Dr. Krakovitz was concerned there might be aortic injury. The bleeding was "retroperitoneal" (meaning in the space that contains the kidneys, pancreas, abdominal aorta and other organs). Drs. Krakovitz and Goel reached a conclusion that a vascular surgeon should be brought in for consultation and assistance with the bleeding (Krakovitz Deposition, pp. 183 -189).

Dr. Fishman's Surgical Intervention

At the time of the call, Dr. Fishman was at home with his family. The call to Dr. Fishman was made by a nurse at the Hospital identified as "the circulating nurse" (Krakovitz Deposition, pp. 113-118). According to Dr. Fishman, the caller informed him that Dr. Goel was asking him to come to the hospital because the patient (the Plaintiff) "was bleeding to death." (Fishman Deposition, p. 62). The Defendant left home immediately and arrived at the Hospital within ten to twenty minutes of the call. According to the Operative Report (Exhibit M, p. 435), Dr. Fishman arrived at the O.R. at 6:15 p.m. (1815 hrs.), two hours after the start of Dr. Krakovitz appendectomy surgery with the Plaintiff, and eighteen minutes after Dr. Goel's arrival.

Upon arrival, according to Dr. Krakovitz, Dr. Fishman was informed that there was a hematoma in the Plaintiff's mesentery. Dr. Krakovitz stated this was seen by him upon surgically "opening [the Plaintiff] up" but could not see where the bleeding was coming from. Dr. Krakovitz expressed his concern to Dr. Fishman that the Plaintiff may have had a major vascular aortic injury (Krakovitz Deposition, p. 193).

Dr. Fishman began treatment by surgically extending the port near the umbilicus. This was done to get better exposure and proximal control of the aorta. Neither Dr. Krakovitz nor Dr. Goel, at this point, were certain about the location and source of the blood flow. Nevertheless, at his deposition, Dr. Krakovitz did note that during a laparoscopic appendectomy, it is possible that a surgical instrument, or port, could have injured one of the vessels during the appendectomy (Krakovitz Deposition, pp. 135-138).

In any event, Dr. Fishman undertook to pack the abdomen with "lap pads" until the bleeding was closed and the flow was blocked (i.e. "tamponated"). Fishman Deposition, pp. 71-72). Dr. Fishman next undertook to identify the area of injury by slowly removing the lap pads. This revealed a source of the bleeding that was the inferior branch of the superior mesenteric artery. Dr. Fishman tied it off with clips and sutures and stopped the bleeding at that location (Fishman Deposition, pp. 73-74).

Fishman then resumed slow removal of the lap pad packing. He discovered that the middle of the abdomen had severe arterial bleeding. The anesthesiologist was directed to continue transfusing "large amounts of blood" (fresh frozen plasma known as FFP, packed red blood cells, and platelets) to prevent disseminated intravascular coagulation (DIC) which, if not properly undertaken, could cause body tissue and organ damage; even death.

The abdomen was re-packed and Dr. Fishman resumed searching for other sources of bleeding. He discovered a significant amount of venous bleeding in the upper right flank area of the abdomen and kept pressure on the arterial part of the bleeding. Dr. Fishman saw that the right renal vein had a laceration and he repaired it (Fishman Deposition, pp. 75 and 89).

Another vascular surgeon was paged to assist Dr. Fishman in the effort to stop the bleeding. According to the Operative Report, Dr. Richard Schutzer, a vascular surgeon, responded and joined Fishman and the other surgeons at 8:00 p.m. (2000 hrs.).

As set forth in the Operative Report submitted by Dr. Fishman (Exhibit M, p. 435), the attention of both Dr. Fishman and Dr. Schutzer was then turned to the superior mesenteric artery (SMA) (Fishman Deposition, p. 92). Initially, evaluation was made of the other arteries in the area. This included the aorta, the cava, the kidney, the other renal vein and any other vessels in the area (Fishman Deposition, p. 89).

The SMA was found to be lacerated on both the anterior and posterior surfaces through and through. In addition, there were five small branches coming off of the artery. Both Dr. Fishman and Dr. Schutzer engaged in the effort to repair the SMA as well as the branches that were "coming off" (Fishman Deposition, p. 89).

The Operative Report of Dr. Schutzer (Exhibit M, p. 424) states that upon joining Dr. Fishman in the O.R., he observed a proximal clamp on the mesenteric artery with several sutures and clips in the area and persistent bleeding on both anterior and posterior surfaces. The clamp was released and the artery was repaired with 6-0 Prolene sutures, and Surgicel was placed on the deep artery where a small venous ooze was noted. They were successful and they were able to stop the bleeding. Warm saline irrigation with antibiotics was then employed. Surgicel,

Gelfoam and Thrombin were applied to any raw surfaces. Full inspection of the abdomen was done and all bleeding had been controlled. "Hemostasis [was] achieved." See, Operative Reports, p. 424, and p. 432.

At this point, Drs. Fishman and Schutzer returned treatment of the Plaintiff back to Dr. Krakovitz and Goel who ". . . reapproximated the different layers in the standard fashion for closure of the abdomen." They observed that the small intestine remained pink and demonstrated "normal peristalsis" throughout the operation (muscle constriction that helps to reduce and move food particles through the stomach and small intestine). See, Operative Report, Exhibit M p. 428. The surgery having concluded, the Plaintiff was then transferred to the Intensive Care Unit (ICU) for recovery. The Plaintiff was intubated and was evaluated as in critical, but stable, condition. See, Operative Report, Exhibit M, p. 432.

There is no dispute that the Plaintiff's main colo-rectal surgeon, leading up to and into the appendectomy to remove the appendix and the "mass," was Dr. Krakovitz. The initial effort by Dr. Krakovitz to surgically remove the appendix was not a surgical procedure unfamiliar to him. Nevertheless, the appendectomy ran into an unanticipated emergency; i.e., uncontrolled bleeding in the abdomen. The unidentified source of the bleeding within the Plaintiff's abdomen created an emergency situation requiring immediate surgical intervention by Dr. Fishman, the vascular surgeon who was on call.

Claims of Medical Malpractice

What created the bleeding during the appendectomy of the Plaintiff is not set forth by the Plaintiff. This does not, perforce, mean that the emergency was created by the Plaintiff's surgical physician, Dr. Krakovitz. However, it should be noticed that a stipulation executed by Plaintiff's

counsel on August 19, 2020 specifically withdrew the Plaintiff's allegation that the Defendant "Eric Fishman was negligent and careless in 'performing a laparoscopic appendectomy, attempting to insert a 5-mm bladeless Visiport into the upper quadrant of plaintiff's abdomen,' and 'manipulating the appendix with a bowel grasper.'" The stipulation was filed on NYSCEF on October 2, 2020 as NYSCEF Doc. No. 140. The above allegations of the Plaintiff, (directed against the Defendant Doctor Fishman) as stated and executed by the Plaintiff in the stipulation, are thus hereby dismissed in their entirety by the Court.

However, an unnamed "General Vascular Surgeon" (GVS), was retained by the Plaintiff as an expert in opposition to the Defendant's motion. The expert's affirmation in opposition contains numerous conclusions claiming that, within a reasonable degree of medical certainty, Dr. Krakovitz departed from the standard of care in his treatment of the Plaintiff, and thereby directly and proximately caused the Plaintiff serious and permanent injuries. The facts in support of the GVS expert's conclusions seem to rest on, or revolve around, the decisions by various other defendants (including Dr. Krakovitz) to not make a motion of their own, and ". . . to be let out of the case" (See GVS's Affirmation at ¶ 13).

For reasons that are not clear, Dr. Fishman's surgical intervention to stop the Plaintiff's bleeding is almost completely overlooked by the Plaintiff's GVS expert. Nevertheless, the GVS expert concludes (without adequate support) that virtually all of the Defendants in the instant case were, in some way or another, negligent.

In any event, whether Dr. Krakovitz departed from the standard of care in his treatment of the Plaintiff, that is not the issue in the instant motion before the Court. The issue now before the Court is whether Dr. Fishman's life saving surgical intervention, commenced at the request of the

Hospital and colo-rectal surgeon Dr. Krakovitz, led to medical malpractice on the part of Dr. Fishman, either surgically or post operatively.

What is alleged by the Plaintiff's GVS expert, is that despite Dr. Fishman's emergent surgical intervention to stop the Plaintiff's internal bleeding, and essentially save the Plaintiff's life, Dr. Fishman "departed from the standard of care in [his] treatment of [the Plaintiff] Mr. Davis." GVS's Affirmation at ¶ 4. Without setting forth the nature of the "greater harm" to the Plaintiff alleged to have been caused by Defendant Fishman, it seems that the GVS expert simply asserted an allegation of failure on the part of Dr. Fishman, for not immediately diagnosing, post-operatively, the possibility of mesenteric ischemia (which was not conclusively diagnosed by anyone until May 7, 2017 when the Plaintiff was transferred to Colombia University Medical Center). However, the emergent surgical acts of Dr. Fishman on April 28, 2017, acts that stopped the greater possible harm of Plaintiff bleeding to death, is not addressed by the GVS expert. What is evident is the failure of the GVS expert to acknowledge and address the emergent nature of Dr. Fishman's call from the Hospital and the work Dr. Fishman performed that essentially saved the Plaintiff's life. The Plaintiff's expert nevertheless concludes in his affirmation that the Defendant's motion for summary judgment should nonetheless be dismissed. See GVS's Affirmation at ¶ 4.[1] The Court, respectively disagrees.

There is no offer of certainty by the Plaintiff's GVS expert that, mesenteric ischemia was

[1] The affirmation of the GVS expert, on the surface, is directed at the Defendant Dr. Fishman. However, there are no fewer than eighteen physicians of various specialties who, in the affirmation, are the subject of the expert's conclusions alleging departures from the standard of care by all who came into treatment contact with the Plaintiff. This includes Lawrence Hospital as the Hospital entity, Dr. Fishman and Dr. Schutzer as "the Vascular Surgeons," and the rest who are referred to as "the ICU Defendants" who took charge of the Plaintiff's post operative treatment.

present or imminent at the conclusion of Dr. Fishman's surgery on April 28, 2017. What is offered by the GVS expert is not the presence of fact, but rather the presence of the possibility of fact. The lack of certainty is expressed in the GVS expert's affirmation at paragraph 6 under "Medical Information." According to the GVS expert, ". . .[m]esenteric ischemia usually occurs when one or more of the mesenteric arteries narrows or becomes blocked [and] . . . when the blockage occurs, the patient can experience severe abdominal pain . . . [and] mesenteric ischemia can be either chronic or acute." GVS affirmation at ¶ 6. The condition of the mesenteric arteries at the time of their repair is well established in the operative reports and testimony of the vascular surgeons. At no time does the GVS expert establish, much less assign, surgical causation to the ischemia condition that Plaintiff developed post surgery, and was later detected by Colombia University Medical Center on May 7, 2017. The GVS expert does not establish any causation of mesenteric ischemia by Dr. Fishman via surgical action, or surgical non-action by Defendant Fishman, other than drawing a conclusion that the Defendant Dr. Fishman did not spend sufficient time with the Plaintiff post surgery. GVS affirmation at ¶ 22. As was obvious to all engaged in post surgical treatment (including the vascular surgeons), the Plaintiff's post operative need of intubation and sedation, while not ideal to conduct full examination, was important to give meaningful time to the Plaintiff's recovery and meaningful evaluation of the recovery thereof.

It cannot be disputed that upon arrival at the Hospital on April 28, 2017, Dr. Fishman's immediate (and critical) task was to stop the bleeding that had erupted in the Plaintiff's abdomen, and was somehow caused during the appendectomy performed by the colo-rectal surgeons. As previously stated, Dr. Fishman arrived at the Hospital roughly10 minutes after the call from the

Hospital was made. The bleeding problem that arose after removal of the appendix and cystic mass was what led to the emergency call to Dr. Fishman. Putting a stop to the bleeding was the priority that required surgical intervention by Dr. Fishman. The life threatening condition (excessive bleeding) that occurred during the appendectomy, could not be resolved by the colo-rectal surgeons involved in the appendectomy. The bleeding thus needed immediate attention by the vascular surgical specialist: Dr. Fishman.

In addition to the sworn depositions of the Doctors that participated and observed what occurred in the O.R. on April 28, 2017; in addition to the Operative reports issued by the Doctors; there is a lengthy evaluation by Dr. Todd Berland, the Defendant's expert, (certified in both vascular surgery and general surgery), of the work performed by Dr. Fishman in the O.R., and, the work he performed during the followup evaluation by the ICU. In his affirmation, Dr. Berland spoke at length about the surgical intervention undertaken by Dr. Fishman, and states as follows:

> It is my opinion that every aspect of Dr. Fishman's repair of the inferior mesenteric, right renal vein, and superior mesenteric artery was performed appropriately and within the standard of care. He used the correct instruments and surgical equipment to locate the lacerations and perform the repair, including sutures, vascular clips, DeBakey pickups, vessel loops, and vascular retractors. Dr Fishman essentially saved this patient's life by stopping life-threatening bleeding and repairing the three blood vessels in a timely and appropriate manner. . . [I]f Dr. Fishman's repair had not been timely, this patient would have died of blood loss. . . . [N]o other surgical or vascular intervention was necessary to repair the vessels other than the repairs performed. A bypass, patch angioplasty, stenting, or other procedures were not indicated because there was significant blood loss with persistent bleeding that needed to be controlled as soon as possible. This was a lifesaving procedure at a time when there were three vessels that needed to be repaired. Berland affirmation at ¶¶ 24-25.

The Court has fully reviewed (and discussed herein) the Operative Reports and testimony

of the Defendant Doctors involved in the Plaintiff's appendectomy and the emergent surgical treatment that arose on April 28, 2017. There is no discussion or analysis by the Plaintiff's GVS expert, of Dr. Fishman's April 28, 2017 surgical efforts to stop the Plaintiff's bleeding other than saying that a CT study should have been done at some point, immediately or soon after surgery, to detect whether mesenteric ischemia had set in, and that as a result Dr. Fishman, Dr. Schutzer, and ". . . each and every ICU Defendant . . . all departed from the standard of care when they failed to consider mesenteric ischemia in a differential diagnosis." GVS affirmation at ¶ 47.

The only basis offered for the GVS expert's conclusion is speculative. Ironically, it appears in his affirmation where he states ". . . [i]t is further my opinion that had any one of the Vascular Surgeons or the ICU Defendants performed a CTA ***to rule out*** (emphasis added) bowel ischemia, alternative forms of vascular repairs would have been available, including a thrombolytic agent and surgical repair of the SMA. GVS affirmation at ¶ 47. This is a clear indication that even the GVS expert did not express full confidence in the use of the CTA to determine the presence (or absence) of bowel ischemia. By his own admission, the most that can be stated is that use of the CTA might, or might not, have found bowel ischemia. What then, given the distinct possibility of a "CTA bowel ischemia rule out," are the alternative forms of vascular repairs: "[S]urgical repair of the SMA" (which was done by Fishman and Schutzer on April 28, 2017)? "[B]owel resection?" (which could not be done, given the Plaintiff's post-op condition, prior to transfer out of Lawrence Hospital on May 7, 2017). GVS affirmation at ¶ 47.

The Operation Reports are not disputed by the parties and plainly state that the Plaintiff's bleeding was stopped by the combined efforts of Drs. Fishman and Schutzer. The operation report clearly states that (upon inspection) the small intestine remained pink and demonstrated

normal peristalsis. Moreover, if at this time ". . . the bowel was not receiving adequate blood flow, it [the small intestine] would be dark, discolored, and there would be no peristalsis" (see, Dr. Berland affirmation at ¶ 23).

The operation report went on to state that warm saline irrigation with antibiotics was employed immediately after the SMA was repaired and the bleeding was stopped (see, Berland affirmation at ¶ 14). Also, Surgicel, Gelfoam and Thrombin were applied to any raw organ surfaces to help block infection, and after stopping the bleeding a full inspection of the abdomen was done and all bleeding had been controlled. Hemostasis was achieved. (See, Operative Reports, Exhibit M, pp. 435 424, 428,432, and 435).

Thus, the Plaintiff's GVS expert's affirmation speaks solely on the question of post operative treatment of the Plaintiff by Dr. Fishman and the medical personnel assigned to the ICU. Nevertheless, as stated "in Sum" by the GVS expert, ". . . it is [the GVS expert's] opinion to a reasonable degree of medical certainty that the Vascular Surgeons [Fishman and Schutzer] and the ICU Defendants all departed from the standard of care in their treatment of Mr. Davis by failing to monitor Mr. Davis and . . . rule out bowel ischemia." GVS Affirmation ¶25.

In the GVS expert's view of the medical malpractice claims filed against the Defendant Dr. Fishman, Fishman is essentially viewed as the Plaintiff's doctor and was the supervising Lawrence Hospital employee. This is a mistaken view. As stated by Dr. Berland in his affirmation, "[a]s an intro-operative consultant, Dr. Fishman was not responsible for the supervision or monitoring of the primary surgeon, Dr. Krakovitz, or the other consultants called, none of which were Dr. Fishman's employees." Berland affirmation at ¶ 27.

Dr. Fishman was certainly the emergency Doctor who stopped the Plaintiff's bleeding, but

Dr. Krakovitz was: (1) the Plaintiff's doctor at all times prior to pre-op; (2) was the doctor during surgical appendix removal; (3) was the doctor at the end of the surgery when the bleeding had been stopped, and; (4) was the doctor during the post-op time of Plaintiff in ICU.

Dr. Fishman, on the other hand (and as previously stated), was an independent physician on call who was not requested by the Plaintiff to be the surgeon to perform his appendectomy. Dr. Fishman was called by Lawrence Hospital for the purpose of consultation and emergency surgical intervention.[2] GVS affirmation at ¶¶ 31-32.

Post-operative, Dr. Krakovitz, ICU, and Lawrence Hospital could have requested consultation from Dr. Fishman, as was done during the surgery, They did not do so. As stated in his report, Dr. Berland noted that "[a]fter the first 48 hours after the surgery . . . [Dr. Fishman] would have some involvement in the [Plaintiff's] care as it related to the vascular repair; however, the patient's care would predominantly be managed by the . . . Intensive Care Unit," but, "Dr. Fishman . . . was not called for a consult on this patient at any point after April 30, 2017." Dr. Berland affirmation at ¶ 17.

Despite the omission of this fact by the GVS expert, Dr. Fishman still used his own time and judgment to monitor the Plaintiff on April 28, 29, and 30, 2017. On Dr. Fishman's first post-op examination of the Plaintiff on April 28 2017, it was determined that the Plaintiff's lactate level was elevated at 5.7. At 5:30 a.m. on April 29, 2017, the Plaintiff's lactate acid level had decreased to 3.8 mmol/L. By mid-afternoon on April 30, 2017, the Plaintiff's level had decreased to 1.7 mmol/L, which is the normal level. The Plaintiff remained hemodynamically stable (i.e., a

[2] The GVS expert also neglected to note that during the time after his surgery, the Plaintiff was intubated and, therefore couldn't speak, but remained hemodynamically stable.

stable blood flow, pumping heart, and good circulation). During the course of the above 48 hour time period the Plaintiff remained intubated, which of course limited examinations by Dr. Fishman as well as all of the treating surgeons.

On April 30, 2017, Dr. Fishman recommended transfer of the Plaintiff to a tertiary care center. On May 7, 2017, the Plaintiff was transferred to New York Presbyterian Hospital (NYPH) by Lawrence Hospital ICU so that the Plaintiff's medical needs could be addressed more fully.

As noted in the affirmation by the Defendant's expert (Dr. Berland), Dr. Fishman ". . . followed Mr. Davis [post-op] and monitored specifically for peritonitis and high lactate, which could indicate that the plaintiff was not receiving adequate collateral blood flow to the organ where the vessel was damaged.[3] Dr. Fishman found ". . . no evidence of bowel ischemia based on blood work, lactate levels, and lack of peritonitis. As stated above, lactate levels had initially been high immediately after surgery (which was not unusual because of the Plaintiff's operative bleeding), but the lactate levels trended downward over the following days and had normalized as of April 30, 2017. Berland affirmation at ¶ 16. Berland went on to state that "[l]actate is the best marker for bowel ischemia and Mr. Davis' lactate levels were properly monitored following the surgery." Berland affirmation at ¶ 28.[4]

According to Dr. Berland, in addition to post surgical lactate level monitoring, Dr. Fishman properly evaluated the Plaintiff for peritonitis, which is inflamation of the abdominal

---

[3] Blood lactate levels are considered to be an important marker in diagnosis of sepsis and is often used in ICU's evaluating response to fluid resuscitation and regional ischemia.

[4] Lactate levels are used by doctors as a marker for the presence of sepsis. A level above 2.1 mmol/L is considered to be a high level and is associated with mortality rates of 28.4%. Rising serum levels of lactate may predict bowel ischemia.

membrane lining covering the abdominal organs. The abdomen, however, was not rigid, which is the proper way to evaluate an intubated patient for peritonitis. Berland affirmation at ¶ 29.

The Plaintiff's GVS expert, makes no reference to Dr. Berland's above referenced facts and analysis, neither by setting forth opposing facts, or by setting forth discrepancies in Dr. Berland's analysis. The Plaintiff's GVS expert simply states that "the standard of care requires that a vascular surgeon like Dr. Fishman monitor a patient like Mr. Davis (the Plaintiff) for a reasonable time following an operation in order to ensure no post-operative injuries or complications develop such as bowel ischemia" (GVS Affirmation at ¶ 22).

What constitutes a reasonable time in the instant case is not set forth by the Plaintiff's GVS expert. Nowhere does the GVS expert state what the "reasonable time" would have been and why the GVS's proposed time (had it been offered) would be reasonable. All the Plaintiff's expert says is that "'[t]he first 48 hours' is an insufficient period of time to monitor a patient who has undergone the extensive procedures, especially when that patient is still intubated and sedated. (GVS Affirmation at ¶ 22).

Without drawing any conclusion about what the reasonable time should have been, the GVS expert simply states that ". . . the standard of care requires that a vascular surgeon like Dr. Fishman monitor a patient like Mr. Davis for a reasonable time following an operation . . . to ensure no post-operative injuries or complications develop, such as bowel ischemia." Again, what is the reasonable time? Should the Plaintiff's intubation have been ceased in order to facilitate the Plaintiff's ability to speak and expand his treatment? Would intubation removal have been harmful to the Plaintiff or helpful? Certainly, lactate monitoring would (and did) show steady lowering of lactate acid in the Plaintiff's blood without the risk of intubation removal.

The Plaintiff's expert answers by stating ". . . had Dr. Fishman properly monitored ***his patient*** (emphasis added), as required by the standard of care, he would have been able to speak to Mr. Davis, to perform a full examination . . ."[5] (GVS Affirmation at ¶ 23). If so, when should this have happened? When would the Plaintiff's ability to speak, return? The intubation was to assist the Plaintiff's ability to breath and recover.

Intubation makes speaking a very difficult, if not impossible task. When would the removal of the Plaintiff's intubation be clearly and safely appropriate? There is no answer to this question by the Plaintiff's GVS expert. To opine that 48 hours was insufficient time for examination of the Plaintiff by Dr. Fishman, as presented, it is simply bald speculation, nothing more.

The Issue of Liability

As previously stated, Dr. Fishman's association with the Hospital was as an intro-operative consultant. On April 27, 2017 he was available to the Hospital as an on call, independent surgeon tasked with preventing the Plaintiff from terminal blood loss. But Dr. Fishman was not as an employee as the term is normally used and understood.

The intro-operative consultant relationship with the Hospital raises and addresses the Plaintiff's allegations against Dr. Fishman claiming medical malpractice. The Plaintiff's GVS expert's allegations assume that certain obligations were owed by Dr. Fishman as a Hospital employee without regard to Dr. Fishman's status as an intro-operative consultant. In any event, as has been previously stated herein, while being available to Hospital call and request for

[5] Again, the Plaintiff was the patient of Dr. Krakovitz who had scheduled removal of the Plaintiff's appendix and cystic mass. Dr. Fishman was called in because of the unanticipated, life threatening abdominal bleeding that occurred during the appendectomy.

consultation, neither the Hospital nor ICU asked for consultation or input from Dr. Fishman post surgery once ICU took charge of the Plaintiff's care after the surgery.

As in the 2021, Second Department case of *Goffredo v. St. Luke's Cornwall Hospital*, 194 A.D.3d 699, 143 N.Y.S.3d 597 (2021), the plaintiff in that case was admitted to Cornwall Hospital while suffering from severe abdominal pain. He was assigned to a physician/employee of Cornwall. The assigned physician reached out to an on-call, "independent" surgeon for a surgical consultation. The consulting, independent doctor came to Cornwall and performed emergency surgery on the plaintiff. However, the plaintiff passed away the following day. The plaintiff's wife, acting as the decedent's representative, sued, *inter alia*, Cornwall, as well as the assigned physician employee, and the on call "independent" surgeon, for medical malpractice. (*Supra* at 598). The Second Department overturned the lower court's ruling denying the plaintiff's motion for summary judgment against Cornwall alleging vicarious liability for acts and omissions by the independent surgeon. *Id.*

"[U]nder the doctrine of respondeat superior, a hospital may be held vicariously liable for the negligence or malpractice of its employees acting within the scope of employment, but not for the negligence or malpractice of an independent physician . . ." However, the hospital may be held vicariously liable for the acts of independent physicians where the patient is admitted for emergent hospital treatment [such as stopping uncontrolled bleeding as is the case herein], not emergency treatment from a particular hospital physician sought by the patient. *Id.* See, also, *Pinnock v. Mercy Med. Ctr.* 180 A.D.3d 1088, 119 N.Y.S.3d 559 (2d Dep't 2020)(summary judgment granted where plaintiff's expert, in opposition to motion of the defendant surgeon and consultant, did not provide any basis for his opinions that an emergency appendectomy was not

required in light of the pathology findings of acute appendicitis or that the plaintiff's pelvic mass should have been treated in the emergency department). *Supra* at 1092.

As in the above cited cases, in the instant matter and the attendant motion and opposition thereto, there is clear evidence and legal proof set forth by the Defendant that makes a prima facie showing that there were no departures from accepted community standards of medical care, and that there were no acts by the Defendant which were a proximate cause of the Plaintiff's injuries. See, *Pinnock, supra*, at 1090. Neither the Plaintiff nor the GVS expert have made a showing of admissible material facts to rebut the prima facie showing of facts by the Defendant and his expert Dr. Berland.

In addition to the GVS expert's conclusions in opposition to the Defendant's motion for summary judgment, the Plaintiff also offers the opinions from two other experts. Neither are surgeons, vascular or otherwise.

The Plaintiff's unnamed second expert is a "Critical Care Specialist" (CCS) who's area of practice is "Internal Medicine" and is certified in pulmonary disease. In addition to not having surgical experience, the CCS expert makes no claim of surgical experience, vascular or colo-rectal (see, CCS affirmation at ¶ 1). To no surprise, this expert overlooked, and failed to address, the weight of the events that transpired in the O.R. which were undertaken and necessary to save the Plaintiff's life. The Plaintiff's CCS expert drew conclusions limited to Dr. Fishman's supplemental examination of the Plaintiff while the Plaintiff was under post-op treatment by the Hospital ICU doctors. The CCS expert concluded that Dr. Fishman's conclusion of "no evidence of bowel ischemia" was not supported by written documentation (which is untrue).

The conclusion by Dr. Fishman that there was no evidence of bowel ischemia was based

on both the Plaintiff's monitored lactate findings as well as the Plaintiff's lack of peritonitis (see, Berland affirmation at ¶ 16). What then was the basis of Plaintiff's CCS expert opinion? No facts in support of the "affirmed" opinion of the CCS were presented, analyzed and offered. The CCS's conclusions ignored Dr. Fishman's examinations of the Plaintiff on April 28, 29, and April 30, 2017 as noted in the Plaintiff's ICU progress notes as described by Dr. Fishman in his deposition (see, Fishman deposition at pp. 35-39 and pp. 42-48). The Plaintiff's CCS expert made no mention of the Plaintiff's continued, post O.R. intubation by the ICU, and no mention of the need therefore.

Dr. Berland, on the other hand, covered all of the events surrounding Plaintiff's treatment, including Dr. Fishman's actions in the O.R. and his post operative ICU examinations and non-surgical treatment. Other than offering bald conclusions, there is a rather complete absence of relevant facts and analysis on the part of the CCS expert.

The third expert offered by the Plaintiff in opposition to the Defendant's motion for summary judgment is an unnamed radiologist. Nowhere in the Radiological expert's affirmation is there an allegation that Dr. Fishman departed from standard of care of the Plaintiff either surgically or post surgically. Dr. Fishman's name does not appear in the affirmation, either directly or indirectly. The unnamed Radiologist instead speaks of the standard of care ". . . when a radiologist encounters . . . radiological findings, [and] must report them immediately as an indicator of bowel ischemia." Radiologist affirmation at ¶ 11. Dr. Fishman was not, and is not, a radiologist. He was not shown radiological studies of the Plaintiff made by Lawrence Hospital staff.

According to the Radiologist expert, the radiological study at issue was performed on May

5, 2017. It was released to ICU Attendings (not Dr. Fishman) on May 6, 2017. The Lawrence Hospital radiologist made the study at the request of the ICU for a radiological CT study of the pancreas. In the study, there was an incidental finding of a ". . . narrowing of the distal portion of the SMA" by the hospital radiologist. It initially went unreported. When the ICU Attendings viewed the study they are alleged to have not embraced a finding of bowel ischemia and continued to attribute the Plaintiff's symptoms and complaints to pancreatitis. According to the Radiologist expert, the failure of the Attendings's to accept the possibility of ischemia departed from the standard of care. They are alleged to have done so by ignoring it and as a result, were responsible for direct proximate cause of the Plaintiff's "injuries." Radiologist affirmation at ¶¶ 14-17.

Nevertheless, there is no claim by the Radiologist expert that Dr. Fishman had any part in the actions of the ICU Attendings at the stated time of May 6, 2017. There is no claim by the Radiologist expert that Dr. Fishman departed from the standard of care, proximately causing injuries to the Plaintiff.

Summary judgment is generally not appropriate in a medical malpractice action where the parties adduce conflicting medical expert opinions, since conflicting expert opinions (usually) raise credibility issues which can only be resolved by the jury or fact finder. *Pinnock v. Mercy Med. Ctr*, 180 A.D.3d 1088, 1090, 119 N.Y.S.3d 559 (2d Dep't 2020); *Feinberg v. Felt*, 23 A.D.3d 517, 519, 806 N.Y.S.2d 661 (2d Dep't 2005). However, "expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact." *Wagner v. Parker*, 172 A.D.3d 954, 955, 100 N.Y.S.3d 280 (2d Dep't 2019); *also see, Diaz v. N.Y. Downtown Hosp.*, 99 N.Y.2d 542, 544 (2002)("[w]here the expert's ultimate assertions are speculative or unsupported by any evidentiary foundation, ... [his or her] opinion should be

given no probative force and is insufficient to withstand summary judgment"). "In order not to be considered speculative or conclusory, expert opinions in opposition should address specific assertions made by the movant's experts, setting forth an explanation of the reasoning and relying on 'specifically cited evidence in the record' " (*Tsitrin v New York Community Hosp.*, 154 AD3d 994, 996 [2017], quoting *Roca v Perel*, 51 AD3d 757, 759 [2008]). "An expert opinion that is contradicted by the record cannot defeat summary judgment" (*Bartolacci-Meir v Sassoon*, 149 AD3d 567, 572 [2017]). *Lowe v. Japal*, 170 A.D.3d 701, 702–03, 95 N.Y.S.3d 363 (2019) Expert opinions that are conclusory, speculative, or unsupported by the record are insufficient to raise triable issues of fact (see *Bowe v Brooklyn United Methodist Church Home*, 150 AD3d 1067, 1068 [2017]; *Kerrins v South Nassau Communities Hosp.*, 148 AD3d 795, 796 [2017]; *703 *Spiegel v Beth Israel Med. Ctr.-Kings Hwy. Div.*, 149 AD3d 1127, 1128 [2017]). These are the issues on the motion before this Court.

In the Court's view the Plaintiff's expert's ultimate assertions of the possibility of bowel ischemia are speculative or unsupported by any evidentiary foundation. None of the experts retained by the Plaintiff were, at any time, capable of showing when bowel ischemia developed in the Plaintiff, and how it developed. Speaking only of the possibility of it's presence, the Plaintiff's experts relied solely upon certain symptoms exhibited by the Plaintiff post-op and during ICU treatment.

Leukocytosis for example, cited by Plaintiff's GVS expert, and which involved the growth of white blood cells in the Plaintiff's system post-operatively, could possibly have occurred from intestinal bleeding. There is no question there was a dangerous level of intra-abdominal bleeding prior to the Defendant's surgical actions to stop it. However, in his affirmation, the GVS expert

never assigned any specific connection between white blood cell growth in the Plaintiff (immune system response?) and bowel ischemia. As previously set forth by the Defendant's expert, the Plaintiff's monitored lactate findings (which normalized as of the Plaintiff's third day in the Lawrence Hospital ICU), as well as the finding of the Plaintiff's lack of peritonitis, were clear and were the best indicators of the absence of bowel ischemia at those times. Again, the GVS expert made no mention or analysis of the Plaintiff's lactate findings and lack of peritonitis findings and how that would suggest (or not suggest) the cause of Plaintiff's bowel ischemia.

Moreover, how the Plaintiff's GVS expert could assign to the Defendant a departure from the standard of care for undertaking only a 48 hour post-op monitoring of the Plaintiff (and being "ten hours short" of 48 on day three in the process), and not citing "a more reasonable (but undesignated) time" of monitoring is interesting. Given the uncontested fact that Dr. Fishman was available for consultation after 48 hours, he was not called for consultation by either Lawrence Hospital, or the ICU, at any time after the 48 hour period.

The Defendant Dr. Fishman has established prima facie entitlement to judgment as a matter of law. For all of the reasons set forth herein, the Plaintiff's pleadings and offerings in opposition to the Defendant's motion are insufficient to raise triable issues of fact on the question of whether the Defendant departed from good and accepted medical practice and whether such departures were a proximate cause of the Plaintiff's injury from bowel ischemia. Accordingly, it is hereby

ORDERED, that so much of the motion by the Defendant Dr. Eric Fishman (Motion Seq. No. 4) seeking summary judgment against the Plaintiff James Davis, is granted and the Plaintiff's complaint against the Defendant Dr. Eric Fishman is hereby dismissed.

The forgoing constitutes the Decision and Order of the Court.

Dated: White Plains, New York
September 3, 2021

James W. Hubert, J.S.C.